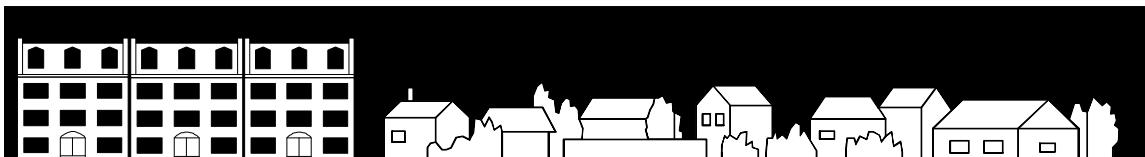


From Institutions to Communities:



Services to Tennessee's Mentally Retarded and Developmentally Disabled Citizens

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Executive Summary

Prior to the 1970s, the prevalent form of state-administered services to mentally retarded/developmentally disabled individuals was through large state institutions. In the 1970s, the number of small, community-based residential facilities increased substantially. In 1981, the United States Congress added a section to the Social Security Act that facilitated a move away from institutional care by granting states greater flexibility in offering community-based care. Today, there are more than twice as many mentally retarded/developmentally disabled individuals receiving services in the community than in institutional settings.

In the past several years, policymakers and advocates have debated the best method for providing supports and services to mentally retarded/developmentally disabled citizens. In many states, such as Tennessee, lawsuits over the mistreatment of mentally retarded citizens in state institutions have fueled this debate. Most states have emphasized improving community-based services for mentally retarded individuals, while downsizing large state institutions.

In 1995 and 1996 People First, an advocacy group, and the United States Department of Justice sued the State of Tennessee for violating the civil rights of institutionalized persons. In July of 1997 United States District Judge Robert L. Echols conditionally approved a Settlement Agreement between the parties to the lawsuit.

The intent of the Settlement Agreement is to guarantee the protection of federal statutory and constitutional rights of the persons in the class of citizen established by the agreement. The class consists of all persons who presently reside, will reside, or have resided since December 22, 1992, at one of the three developmental centers named in the lawsuit. The Settlement Agreement establishes guiding principles for both the administration of the developmental centers and placement of individuals in the community. The agreement includes sections relative to state planning, implementation, oversight, evaluations and plan development, and quality assurance, among others. (See pages 8-11.)

The Parent-Guardian Associations have expressed concern over the issue of choice in the Settlement Agreement. The Parent-Guardian Associations have expressed concern that the Division of Mental Retardation Services will use the provisions of the Settlement Agreement to close state-operated developmental centers, leaving developmentally disabled Tennesseans no choice between institutional and community-based care. Both the Settlement Agreement and the home and community-based waiver filed with the Health Care Financing Administration require that the state give residents of developmental centers a choice regarding their participation in the home and community-based waiver. State law, however, gives developmental center superintendents broad powers to determine whether an institutional setting is appropriate in a given case. (See pages 11-12).

In a letter to the Tennessee Attorney General's office, the Health Care Financing Administration established the role of the state in offering institutional services. It is the opinion of the Health Care Financing Administration, that in its role as program administrator, the state must "honor a (Medicaid) recipient's choice of either waiver

services or ICF/MR [intermediate care facilities for persons with mental retardation] services to the extent that the individual is eligible for, and has a need for, either of the services.” The letter also states, however, that in its role as a provider, the state “could eliminate itself as a provider from whom a specific recipient can choose.” In other words, individuals will have a freedom of choice among *available settings*. (See page 12.)

Officials in New Hampshire and Rhode Island—two of the states that have closed all of their large state facilities—point out that most, but not all, individuals were placed in private settings in the community. The agreement requires that an institutional bed be held for each citizen for the six-month period following community placement as a safeguard in case the placement does not meet the individual’s needs. The court’s concern, however, seems to be for the person for whom an appropriate community placement is never found. (See pages 12-13.)

Intervenors have raised objections to the Settlement Agreement on the grounds that it lacks explicit procedures for providing “continuous, competent, and consistent services commensurate with those expected in the community at large.” The intervenors are concerned that individuals who are moving out of developmental centers will not be ensured medical, psychological, and habilitative services equal to the community at large. Division of Mental Retardation Services officials, however, disagree with the Parent Guardian Associations over the interpretation of the Settlement Agreement in this area. (See pages 13-14.)

Some of the strongest objections to the Settlement Agreement have arisen over the issue of funding community placements. The Parent Guardian Associations’ court expert interprets the settlement agreement as giving the state an escape route to avoid the responsibility of funding some of the services in the agreement in their entirety. State attorneys believe that the State of Tennessee is bound by law to perform the duties enumerated in the Settlement Agreement upon approval. State officials contend that although they must meet all of the requirements in the Settlement Agreement, they do not have to go “above and beyond” the requirements. (See pages 14-15.)

State expenditures for mental retardation community services have increased while expenditures for mental retardation institutional services have decreased. The estimated expenditures for mental retardation community services in Fiscal Year 1999 of approximately \$183 million reflect a 15.8 percent increase from the budget of \$154,045,800 in Fiscal Year 1998. The proposed budget for Fiscal Year 1999 included approximately \$154,788,800 in mental retardation developmental center expenditures, a decline of 6.7 percent from the 1998 budget of approximately \$166 million. (See page 15.)

The intervenors have indicated their desire for the number of community placement offices to increase. Tennessee currently operates three primary Regional Offices of Community Services, with two satellite offices. In contrast, the state of New Hampshire, which has operated with no large state institutions since 1991, is divided into 12 regions, with an area agency that oversees each region’s home and community-based services. Florida, which has over twice as many persons living in the community as Tennessee and almost three times the total population of Tennessee, has 15 regional offices of community placement. According to Florida officials, however, there is concern that 15 offices is too many. (See pages 15-17.)

An examination of the data reveals that Tennessee's downsizing of its developmental centers is proceeding at a rate faster than most southern states. The Division of Mental Retardation Services closed the Nat T. Winston Developmental Center in Tennessee in the spring of 1998. West Virginia is the only other southern state planning to close a large state residential facility before the year 2000. In Tennessee, about 22.8 persons out of every 100,000 live in developmental centers, significantly lower than the southern states' average of 27.7. Tennessee also reduced the number of individuals living in large institutions at a faster rate than eight of the 12 southern states examined for this report. (See pages 17-20.)

Administrative Alternatives

- The Division of Mental Retardation Services should explore providing resource centers at the closed developmental centers where citizens could obtain specialized services. The Division should consider maintaining a framework of specialists even after closing Winston and other centers.
- The Division of Mental Retardation Services should consider developing long-term alternatives to private community care. Two states that have closed all of their large institutions have been unable to place all individuals into private, community settings.
- The Division of Mental Retardation Services should consider increasing the number of community placement offices. Small states, such as New Hampshire, currently maintain more community placement agencies than Tennessee. In making this decision, the Division must determine whether investing state dollars into additional community placement offices would actually increase accountability and local control over the community placement process or simply result in increased bureaucracy. (See page 21.)

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Introduction

In the past several years, policymakers and advocates have debated the best method for providing supports and services to mentally retarded/developmentally disabled citizens. In many states, such as Tennessee, lawsuits over the mistreatment of mentally retarded citizens in state institutions have fueled this debate. Most states have emphasized improving community-based services for mentally retarded individuals, while downsizing large state institutions.

This report investigates both the evolution of the home and community-based waiver in the federal Medicaid program and the process by which services offered under this waiver overtook congregate care as the most prevalent form of service provided to mentally retarded/developmentally disabled citizens in the United States. The report also examines the proposed Settlement Agreement that, upon acceptance by the United States District Court, would be the plan of operation for three of the state's four developmental centers for at least the next three years.¹ Some disagreements remain between state officials and Parent Guardian Associations over items in the Settlement Agreement. This report examines some of these disagreements. Finally, the report investigates, analyzes, and compares the status of residential care for the developmentally disabled in Tennessee to the rest of the country and particularly to 12 other southern states.

Methodology

The Comptroller of the Treasury's Office of Research gathered information for this report from interviews with officials from both the Tennessee Department of Mental Health and Mental Retardation (TDMHMR) and the Tennessee Attorney General's Office. Both mental retardation/developmental disability professionals opposed to the Settlement Agreement as well as professionals in the area of developmental services from various other states were contacted in the preparation of the report. The office also examined surveys and reports from, among other sources, the University of Minnesota and the National Association of Directors of Disability Services. Office representatives also attended the early 1997 settlement hearings in the United States District Court for Middle Tennessee.

Background

A historical perspective is helpful in understanding the current circumstances surrounding services for the mentally retarded/developmentally disabled population in Tennessee. The following timeline chronicles the legal action surrounding services for mentally retarded/developmentally disabled Tennesseans.

¹ Proposed Settlement Agreement Section X, Part B, Number 12.

Timeline of Legal Action²

Arlington

Autumn 1990	United States Department of Justice issued findings from its investigation of the Arlington Developmental Center in suburban Memphis.
January 1992	The United States Department of Justice sued the State of Tennessee for violating the Civil Rights of Institutionalized Persons Act (CRIPA) at the Arlington Center.
November 1993	United States District Judge Jon McCalla of Memphis ruled against the state in the Arlington suit.
September 1994	The state entered a remedial order with the United States Department of Justice that stipulated for what relief the state is liable. The federal court subsequently found, on four separate occasions, that the state had not complied with the corrective action stipulated in the order at Arlington, and thus was in contempt.

Clover Bottom, Greene Valley, Nat T. Winston

January 1995	The United States Department of Justice issued findings from its investigations at the state's three developmental centers other than Arlington.
December 1995	People First of Tennessee, an advocacy group for the developmentally disabled, sued the state over violations of the Civil Rights of Institutionalized Persons Act by these three centers. U. S. District Judge Robert Echols of Nashville is presiding over this suit.
April 1996	The state decided to enter a settlement agreement with People First. The U. S. Department of Justice strongly suggested this action.
November 1996	Through a formality to give it standing as a party in the settlement negotiations, the U. S. Department of Justice sued the state over the conditions at these three centers. Judge Echols consolidated the United State's suit with People First's suit.
January and February 1997	Judge Echols held a fairness hearing on the Settlement Agreement. The United States and State of Tennessee argued for the approval of the Agreement, while the Parent Guardian Associations ³ testified against the Agreement.
July 1997	Judge Echols issued conditional approval of the Settlement Agreement, with instructions for the parties to revisit certain issues. He also granted the Parent Guardian Associations <i>intervenor</i> status, which made the association an official party to the suit with standing in the court. Any party could request final approval of the Agreement six months from the date of the conditional approval.

² Chronological information from telephone conversation with Dianne Dycus, Senior Counsel, Office of the Tennessee Attorney General, January 21, 1998; and from Judge Echols' Memorandum dated July 3, 1997.

³ The Parent Guardian Associations are the organizations at the state's developmental centers that are made up of parents and guardians of the individuals who reside in these institutions.

The proposed Settlement Agreement calls for the state, among other things, to provide community services for all institutional residents whose interdisciplinary teams recommend them for community placement. Critics, such as the Parent Guardian Associations, allege that the stipulations of this agreement threaten to move residents out of the developmental centers without the consent of their parents and guardians. Critics of the settlement further claim that such moves would improve the quality of life only for highly functioning individuals in the developmentally disabled population, while jeopardizing the progress that many lower-functioning individuals have made at the state institutions⁴.

Comment by the Deputy Commissioner, Division of Mental Retardation Services:

Research and data from longitudinal studies carried out in states which closed their facilities indicate that the quality of services, supports, satisfaction is better in the community than it was in the institutions.

Evolution of Medicaid Funding

Prior to the 1965 enactment of Medicaid, states received no federal funds for the long-term care of persons with developmental disabilities. Even after its enactment, Medicaid provided matching funds only for persons needing medical assistance. Those who benefited from these federal funds, therefore, were persons in medical institutions, adults in certain skilled nursing homes, and those persons above 65 years of age in state mental hospitals⁵.

These strict requirements for Medicaid eligibility and states' needs for matching funds led 11 states to convert their residential public facilities into skilled nursing facilities by 1969. In their effort to secure the status of "skilled nursing facility" and the subsequent federal funding, state institutions were forced to administer unnecessary and costly medical care to the developmentally disabled.

The impropriety of these conversions of state institutions into skilled nursing facilities generated a movement led by developmental disabilities experts, that sought a new program of Medicaid expenditures. Experts reasoned that a program of financing long-term, non-medical programs for the developmentally disabled would eliminate the need for unnecessary conversions and allow both state and federal funds to be used in a more prudent manner⁷.

In 1967, the "Intermediate Care Facility" (ICF) program was authorized for the elderly and disabled under Title XI of the Social Security Act⁸. The U.S. Congress finally addressed the problem of states overtreating mentally retarded/developmentally disabled (MR/DD) persons by combining the skilled nursing facility and intermediate care facility programs under Title XIX in 1971. This legislation authorized federal financial participation for intermediate care

⁴ Statements from expert witnesses produced by the Parent-Guardian Association at the fairness hearing for the proposed Settlement Agreement, January and February 1997.

⁵ Robert Prouty and K. Charlie Lakin, *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1995* (Report No. 48) (Minneapolis: University of Minnesota, Research and Training Center on Community Living, 1996) 67.

⁶ Elizabeth Bogs, K. Charlie Lakin, and S. Closer, "Medicaid coverage of residential service," In K. Charlie Lakin, B.K. Hill, & R.H. Brininess (Eds.), *An analysis of Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF-MR) Program* (Report No. 20) (Minneapolis: University of Minnesota, Department of Educational Psychology, 1985) 1-9.

⁷ Prouty and Lakin, p. 67.

⁸ Ibid.

performed, among other sites, in state institutions that housed only persons with MR/DD (ICF/MR facilities), thus eliminating the states' practice of intentionally misclassifying persons with MR/DD as needing medical assistance in order to obtain federal funds. States used the new federal funds to benefit those in institutions by both upgrading facilities for persons with MR/DD and implementing active treatment programs for MR/DD rather than for contrived medical problems.

Criticisms of the administration of the intermediate care facility program began soon after its implementation. The criticisms of the early results of the ICF/MR program were brought on roughly the same grounds that caused its authorization—that the system of federal fund distribution currently in place was increasing the inappropriate treatment of persons with MR/DD. Critics argued that the ICF/MR program's federal financial participation in financing institutions for persons with MR/DD had created incentives for states to maintain institutional populations. Critics argued that ICF/MR programs encouraged states to provide treatment in institutions without consideration to the individual's situation or the severity of his or her MR/DD. According to detractors of the ICF/MR program, many of the persons in state institutions would have a higher quality of life in smaller community settings, but states were reluctant to finance such facilities for fear of losing federal financial participation.

In response to criticisms of the results of the ICF/MR program, the Health Care Financing Administration clarified how states could receive ICF/MR funding in smaller group homes. The regulations for ICF/MR programs, published in 1974, explained that Congress had authorized ICF/MR funding for facilities with "four or more people," regardless of whether they were public or private.⁹ Additionally, the regulations acted to encourage smaller congregate care facilities by allowing greater flexibility to meet the ICF/MR standards for facilities with 15 or fewer residents.

Even though the number of small community-based residential facilities increased significantly in the late 1970s and early 1980s, the increase was not evenly distributed across the country. For example, in 1977, 65 percent of the community ICF/MR's were located in just four states: Texas, New York, Michigan and Minnesota.¹⁰ Recognizing this problem, in 1981 the Health Care Financing Administration issued "Interpretive Guidelines" as part of an effort to clarify again the law regarding community ICF/MR's. Although the significant rise in the number of states that then developed small ICF/MR facilities after this clarification suggests that the guidelines produced the desired effects, another dramatic policy shift was about to occur.

On August 13, 1981, Congress added Section 1915(c) to the Social Security Act: the Medicaid Home and Community Based waiver authority. This change in the law resulted in greater flexibility for states to offer home and community-based services for the mentally retarded and developmentally disabled and further facilitated a move away from congregate care.

⁹ Ibid, 68.

¹⁰ Ibid, 69.

Medicaid Home and Community-Based Waivers

The Home and Community Based Waiver offers states an alternative to institutional care. The Department of Health and Human Services allows states to devise a plan, in accordance with certain specific guidelines, that offers a schedule of home and community-based services to individuals who, without such services, would require the “level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.”¹¹

After approving a plan, the Department of Health and Human Services waives the normal requirements for Medicaid funding and agrees to participate in the funding of “part or all of the cost of home and community-based services (other than room and board)” with Medicaid dollars for individuals who are aged, blind, physically disabled, or mentally retarded/developmentally disabled and who would otherwise receive such services in institutions.¹² All states now have home and community-based (HCB) waiver programs.¹³ Tennessee’s home and community-based waiver program for the mentally retarded/developmentally disabled currently serves over 4,300 people in the HCB waiver with a fiscal year 1998-99 cap of 5,982. The current HCFA approved waiver increases this cap to 6,810 for fiscal year 2000-2001.¹⁴

The waiver granted through Section 1915c of the Social Security Act allows states to offer a broad array of services. The United States Code (U.S.C.) outlines certain home and community-based services that may be provided under an HCB waiver, such as medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health care services, respite care, day treatment or other partial hospitalization services, psychosocial rehabilitation services, vocational services, and clinical services for individuals with chronic mental illness.¹⁵ In addition, the U.S.C. also creates the potential for federal funding of “such other services requested by the State as the Secretary may approve.”

In order to receive federal funding for home and community-based services under a waiver, Section 1915(c) delineates certain specific requirements that states must meet, such as:

- Providing safeguards to protect the health and welfare of persons receiving services under the waiver
- Assuring financial accountability for funds expended with respect to HCBS
- Informing all eligible individuals of alternative services to institutional care
- Keeping average annual per-recipient expenditures below 100 percent of what the expenditures would have been in an institution
- Collecting and reporting annually to the Secretary of DHHS information on the waiver’s impact on the health and welfare of recipients

¹¹ 42 CFR 1396(n), 250.

¹² Ibid, 249.

¹³ Gary A. Smith and Robert M. Gettings, *The Medicaid Home and Community-Based Waiver Program: Recent and Emerging Trends in Serving People With Developmental Disabilities*. (Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, Inc., 1996) 3.

¹⁴ Information provided by Thomas J. Sullivan, Assistant Commissioner Division of Mental Retardation Services, Department of Finance and Administration, State of Tennessee.

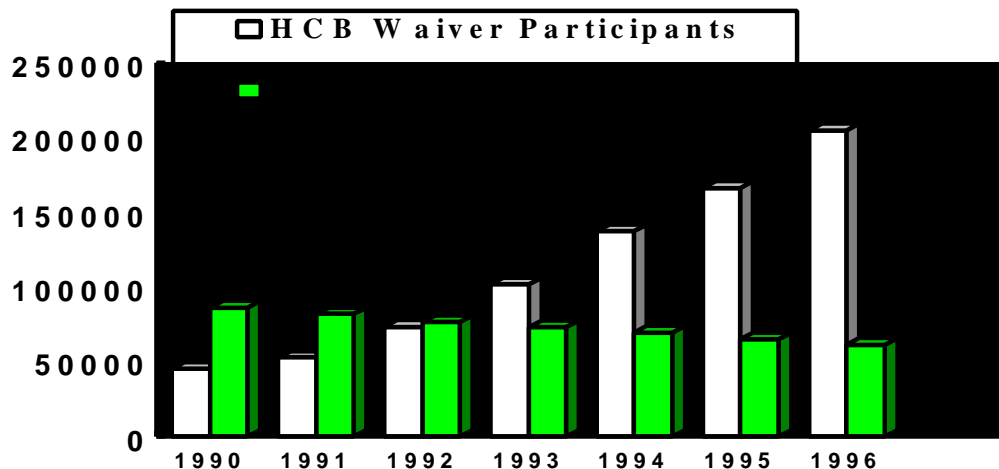
¹⁵ 42 CFR 1396(n), 250.

Other stipulations relating to the home and community-based waiver include:

Time frame. The HCB waiver agreement between DHHS and a state is initially for a term of three years, and, upon the state's request, terms granted thereafter are for five-year periods, assuming a state is in compliance with waiver stipulations.

Eligibility limits. A state may limit the individuals eligible for service under a HCB waiver to those individuals for whom the state has a reasonable expectation that the amount of medical assistance provided under such waiver will not exceed the amount of assistance that the individual would receive if the waiver did not apply.

Number of persons served. The DHHS Secretary may not limit to fewer than 200 the number of persons who may receive HCB services in a state under a Section 1915 waiver. If there is a limit placed on a state's program, the state may substitute new recipients for persons who are no longer eligible through death or other factors for HCB services.



The Medicaid HCB waiver program is a dynamic process.¹⁶ The U. S. Department of Health and Human Services and states often alter their agreements, keeping them fluid to accommodate change and progress. There are approximately one and a half times as many persons in home and community-based settings today as there are in institutional or congregate care settings.

Opponents of total deinstitutionalization, however, question whether or not home and community-based services would be appropriate for all individuals. The critics do not condemn the home and community-based approach, but are cautious. Although certain high-functioning persons may be well served in the community, critics of downsizing warn that the release of certain individuals would certainly threaten their progress. The criticism

¹⁶ Information for the table above is taken from both Gary A. Smith and Robert M. Gettings, *The Medicaid Home and Community-Based Waiver Program: Recent and Emerging Trends in Serving People with Developmental Disabilities* (Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, Inc., 1996) 18; and from Robert Prouty & K. Charlie Lakin (Eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1996* (Report No. 49) (Minneapolis: University of Minnesota, Research & Training Center on Community Living, 1997) 14.

against closing institutions is the same central idea that drove earlier changes in care systems—that a certain type of service, in this case HCB programs and in earlier cases ICFs/MR, is not appropriate for all persons. Deinstitutionalization critics also fear that the oversight of providers will be more difficult when individuals are dispersed all over the state from centralized institutions. Advocates of institutional closings argue that the “least restrictive settings” (in other words, community settings) are the most appropriate for the developmentally disabled and mentally retarded.¹⁷

¹⁷ Information about these points of debate over deinstitutionalization was obtained from the fairness hearing on the proposed Settlement Agreement in the Middle District of Tennessee, U. S. District Court in Nashville, Jan. & Feb. 1997.

Analysis and Conclusions

A Brief Review of the Settlement Agreement

The Settlement Agreement in *People First and the U.S. Department of Justice v. Clover Bottom, et al.* pertains only to Clover Bottom Developmental Center, Nat T. Winston Developmental Center, and Greene Valley Developmental Center. It does not pertain to Arlington Developmental Center, which operates under a remedial order from a previous lawsuit. This settlement represents an attempt to put an end to litigation between the plaintiffs, People First of Tennessee and the U.S. Department of Justice, and the defendant, the State of Tennessee. Since May 1996, all parties have appeared in court numerous times in an effort to reach a fair Settlement Agreement that would be in the best interest of all parties involved. U.S. District Judge Robert L. Echols completed a fairness hearing on the final Settlement Agreement in January and February of 1997. Judge Echols issued conditional approval of the Settlement Agreement in July 1997 with certain concerns highlighted for attention. In January 1998, upon motion by the parties to the suit, the court will reconsider the adequacy of the Settlement Agreement. In its conditional approval, the court also granted the Parent Guardian Associations official “intervenor” status, making them a party to the suit.

The intent of the Settlement Agreement is to guarantee the protection of federal statutory and constitutional rights of the persons in the class of citizens established by the agreement. The class consists of all persons who presently reside, will reside, or have resided since December 22, 1992, at one of the three developmental centers named in the lawsuit. This guarantee of rights would be achieved through “restructuring and enhancing Tennessee’s state-wide system for the delivery of services” to persons of this class. If approved, the agreement, which was entered into voluntarily by the parties, would be legally binding and enforceable as an order of the court.

Guiding Principles The Settlement Agreement’s “Preamble and Guiding Principles” explains the document’s purpose. This section recognizes, among other points:

- The role of the family/guardians in the rendering of services to the class;
- The importance of providing services in the “least separate, most integrated setting” possible;
- The need for person-centered decisions regarding care of the individual, driven by the individual citizen, family members/guardians, advocates and professionals;
- The need for the provision of services in the individual’s home community such as adapted homes; the development of strong relationships with providers, friends, neighbors, and others; involvement in community activities; and, if possible, regular employment;
- The provision of health care, protection from harm, and protection from unnecessary physical and chemical restraints;
- The close monitoring of the provision of services in the community for accountability and quality assurance;
- The lack of expertise and resources at Tennessee’s state institutions; and
- The assurance that the state will provide appropriate alternative placements when an original placement is inappropriate.

State Planning, Implementation, and Oversight Provisions in the Settlement Agreement call for the state to implement the Tennessee Quality Initiative,¹⁸ with one individual assigned to coordinate statewide activity in each of the following areas:

- monitoring and evaluation;
- protection from harm;
- medical care;
- physical and nutritional management;
- behavior intervention;
- habilitation;
- physical environment;
- community placement;
- investigations of alleged abuse, serious accidents and injuries, and other staff misconduct;
- educational services for school-age children.

In addition, the Settlement Agreement mandates that the state assign a Tennessee Quality Initiative director for each developmental center and at each regional office of community services. The state must maintain adequate staff to effectively and appropriately execute the provisions in the Settlement Agreement.

Specifically, the Settlement Agreement notes both the need to enhance staff to disseminate information to the citizens of the class, their families, state agencies, and private organizations, as well as the need for an experienced developmental physician to oversee physicians in the developmental centers. The Settlement Agreement strongly encourages aggressive pursuit of federal and state funding to maintain a level of funding adequate to execute the terms of the agreement, and mandates collecting and maintaining data to monitor the outcome of community programs. It prescribes a partnership between the DMHMR and university-affiliated programs to create curriculum and develop a pool of paraprofessionals skilled in providing community services to the developmentally disabled.

Evaluations and Plan Development The Settlement Agreement provides for a comprehensive, person-centered evaluation for all members of the class to be performed by an interdisciplinary team of the individual citizen, family members/guardians, support staff, advocates, professionals with backgrounds in developing such plans, and any person requested by the citizen. The interdisciplinary team will make recommendations for community placements, taking into account what is important to the person, as well as his or her “medical, behavioral, vocational, social and spiritual needs.” These person-centered assessments will be based on communications with the individual, the individual’s family, friends, support staff and professionals, and the known medical, professional, and social

¹⁸ The TQI is essentially a workplan for the implementation of the proposed Settlement Agreement at the three developmental centers besides Arlington. The state developed the Tennessee Quality Initiative during the Arlington litigation and published it in November 1995. It was both a plan of action for administering the other three developmental centers and a plan for placing persons in the community. By operating under the TQI, the state hoped to avoid any future lawsuits from the Department of Justice. The state’s plan of avoiding lawsuits through the TQI failed. The proposed Settlement Agreement resulted in the evolution of the TQI into the document that it is today.

histories of the individual. If an interdisciplinary team does not recommend an individual for community placement, the individual will be evaluated by experts agreed upon by the parties and independent of the Tennessee Department of Mental Health and Mental Retardation.

From these evaluations, the citizen's individual support and transition plan and its supplements, known as the health care and behavioral support plans, will be formulated. The Quality Review Panel, composed of three expert professionals in the field of developmental disabilities/mental retardation agreed upon by all parties to the litigation, must agree with every independent support and transition plan. Citizens viewed as suitable for deinstitutionalization will receive an individual transition plan from the interdisciplinary team in addition to the individual support plan that all residents will receive. According to the Settlement Agreement, the individual support and transition plan will reflect the individual's vision for his or her life and how this vision can be realized through the development of suitable community services at home, through work/day activities, and through medical services.

For school-age children, the individual support and transition plan must contain an individual education program that specifies a plan for the child's education, including transportation. An independent support coordinator, who will manage the plans of no more than 30 individuals, will oversee each individual support and transition plan. However, the Division of Mental Retardation Services states that they have voluntarily lowered the caseload for class members to no more than 20. The citizen will have input into the selection of his or her independent support coordinator and, if necessary, will have significant input into the changing of the independent support coordinator.

The Settlement Agreement also calls for developmental centers to hold a bed for six months for each citizen in case the community placement fails all efforts to meet his or her needs. If at any point the citizen or his or her family is not satisfied with the adequacy of services in the community, a request for change may be made. After the independent support coordinator exhausts all alternatives for correction, the interdisciplinary team may be reconvened to consider a change in the individual's independent support and transition plan. The Settlement Agreement indicates that these assessments will be based on "the individual needs and choices of the citizen and not on present availability of services." Quality, not time deadlines, will govern this process, according to the Settlement Agreement.

Quality Assurance The intent of community placement is to improve the quality of life for the individual, and to a certain extent, avoid the problems that have been encountered in the institutions. Quality assurance will be the vehicle by which these goals are satisfied. The first order of quality assurance pursuant to the Settlement Agreement are annual reviews of all community-based programs and facilities operated or supported by state funds where former developmental center residents are placed. The purpose of these review is to ensure compliance with terms of the agreement as well as each independent support and transition plan. Satisfaction surveys will also be administered annually to citizens and their families/guardians and the results will be acted on by the Director of the Tennessee Quality Initiative.

Thorough mortality reviews of all deaths in the community are also to be performed by the state defendants for the first two years after the Settlement Agreement is enacted. The

Director of the Tennessee Quality Initiative is to compile mortality and morbidity rates and report them quarterly. After the first two years, thorough mortality reviews will be performed only in cases of suspicious or unexpected deaths. Other informal means will create an extensive quality assurance system through: evolving departmental policies; continuing education of citizens, their families, and support staff; the work of the Director of Tennessee Quality Initiative and the oversight of the independent support coordinator; involvement of advocates; and oversight by the quality review panel. Special attention is also to be paid to those citizens with special needs as well, such as the deaf and blind.

The Settlement Agreement calls for establishing an Office of Investigation that will communicate regularly with the Tennessee Bureau of Investigation, the Comptroller of the Treasury, and federal and local law enforcement agencies. The Office of Investigation will report to the Assistant Commissioner for Mental Retardation Services. It also addresses qualifications for investigators, dissemination of information about the Office of Investigation, education of school age children, and protection of First Amendment rights, and assigns specific audit responsibilities to the Comptroller of the Treasury.

Controversial Aspects of the Settlement Agreement

Issues of Choice

The Parent Guardian Associations have expressed concern over the issue of choice in the Settlement Agreement. The Settlement Agreement allows for choices in several areas. Each citizen, with the help of a case manager, will choose community service providers from those available. Debate remains, however, over the citizen's ultimate choice in the matter of deinstitutionalization—the freedom of choice between remaining in a developmental center or participating in the Medicaid home and community-based waiver. The Parent Guardian Associations have expressed concern that the Division of Mental Retardation Services will use the provisions of the Settlement Agreement to close state-operated developmental centers, leaving developmentally disabled Tennesseans no choice between institutional and community-based care.¹⁹

Part 4, Section V of the Settlement Agreement contains a freedom of choice clause that states “each citizen and his or her parent(s) or legal guardian(s) shall be informed of their freedom of choice regarding participation in the home and community-based waiver.”

The state's approved home and community-based waiver application filed with the Health Care Financing Administration also stipulates that citizens be given a freedom of choice between services in an institutional setting or home and community-based settings. The waiver stipulates that “the individual or his or her legal representative will be given the choice of either institutional or home and community-based services.”²⁰

In contrast to these two freedom of choice provisions, *Tennessee Code Annotated* 33-5-101 authorizes the discharge of individuals from developmental centers at the discretion of the center superintendent. If a superintendent takes the recommendation of an interdisciplinary

¹⁹ Testimony of members of the Parent Guardian Associations at the fairness hearing for the proposed Settlement Agreement, January and February 1997.

²⁰ The State of Tennessee Request for Renewal, Home and Community Based Waiver under section 1915(c) of the Social Security Act, submitted to the U.S. Dept. of Health and Human Services, effective April 1, 1996, p. 7.

team to place a citizen in the community as being in the “best interest” of that citizen, then a superintendent could discharge an individual into the community over the objections of the parents or guardians.

In a letter to the Tennessee Attorney General’s office, the Health Care Financing Administration established the role of the state in offering institutional services. The letter points out that “the State is acting in two roles with respect to the individuals in question. In one role, the State is operating a Medicaid program that pays for services, as a State Medicaid agency. In another role, the State is operating as an institutional provider.²¹ It is the opinion of the Health Care Financing Authority, that in its role as program administrator, the state must “honor a (Medicaid) recipient’s choice of either waiver services or ICF/MR services to the extent that the individual is eligible for, and has a need for, either of the services.”

The letter also states, however, that in its role as a provider, the state “could eliminate itself as a provider from whom a specific recipient can choose.” Ultimately, the state cannot be required to provide institutional services to a person whom it has recommended for home and community-based services, according to the Health Care Financing Authority’s letter. Another way of stating this choice is that citizens shall have freedom of choice *among available settings*. The agreement does call for an institutional bed to be held for each citizen for the six-month period following community placement, only as a safeguard in the event that the placement does not meet the individual’s needs.²² The court’s concern, however, seems to be for the person for whom an appropriate community placement is never found.²³

Officials in New Hampshire and Rhode Island—two of the states that have closed all of their large state facilities—point out that most, but not all, individuals were placed in private settings in the community. In New Hampshire, a few individuals with overwhelming behavioral challenges were placed in mental health institutes,²⁴ whereas Rhode Island established three 15-bed, state-operated residential facilities for individuals with very unusual medical and developmental conditions.²⁵

Administrative Alternative: The Division of Mental Retardation Services should consider developing long-term alternatives to private community care. Two states that have closed all of their large institutions have been unable to place all individuals into private, community settings.

²¹ Letter from Steve McAdoo, Acting Director of the Medicaid Bureau, U. S. Health Care Financing Authority, to Dr. Kathleen Maloy, Assistant Attorney General, State of Tennessee.

²² Proposed Settlement Agreement in *People First, et al. v. Clover Bottom, et. al.*, dated September 27, 1996, Section V, Part B, Number 10.

²³ In the July 3 Memorandum on p. 7, the Court wrote “Will there be an adequate safety net for the severely mentally and physically disabled patients who do not find an appropriate community-based mental health center?”

²⁴ Telephone interview with Joyce Slayton, Associate Director of Developmental Services for New Hampshire, July 18, 1997.

²⁵ Telephone interview with Al Quattromani, Associate Director of the Division of Developmental Disabilities for the Rhode Island Department of Mental Health, Retardation, and Hospitals, 5-1-98.

Comment by the Deputy Commissioner, Division of Mental Retardation Services:

At least four (4) other states and the District of Columbia have closed all their institutions. They may have had some different experiences.

The Issue of Explicit Medical Provisions

Intervenors have raised objections to the Settlement Agreement on the grounds that it lacks explicit procedures for providing “continuous, competent, and consistent services commensurate with those expected in the community at large.”²⁶ The intervenors are concerned that individuals who are moving out of developmental centers will not be ensured medical, psychological, and habilitative services equal to the community at large. Not only must qualified primary care physicians be in the community for every citizen before placement, but this class also needs specialized services, including neurological specialists, doctors with knowledge of metabolic disorders, specialized psychological services, and intense physical and occupational therapy.²⁷

Many members of the class have a fragile medical state. Before placement in the community, the Parent Guardian Associations want a primary care physician established in the individual support and transition plan, as well as available specialists. The current Community Plan for the State of Tennessee allows for moves into the community in cases where specialty supports may not be immediately available.²⁸ In these cases, individuals continue to receive supports from their current provider until one is found in the community. Officials in both Rhode Island and New Hampshire—two of the states that have closed all of their large state institutions—have experienced great difficulty in procuring dental care in the community.²⁹ Tennessee Department of Mental Retardation Services officials have experienced similar difficulties with dental care.³⁰

The intervenors criticize the Agreement on the grounds that it addresses the need for medical specialists in the community, but it does not mandate their presence. In certain instances, the proposed Agreement seems unclear in regard to identifying specialists in the community. For instance, the Agreement states that citizens may choose among available and qualified community service providers.³¹ Further, the proposed Agreement states that specialized medical supports should be integrated into the community *to the maximum extent possible*.³²

²⁶ *People First of Tennessee, ET. AL. v. Clover Bottom Developmental Center, et. al.* Memorandum from Judge Echols date July 3, 1997, p.8.

²⁷ Telephone interview with the Parent-Guardian Associations’ expert Dr. Al Baumeister, Professor of Psychology at Vanderbilt University, July 10, 1997.

²⁸ *My Choice? Ordinary Life: Community Plan for the State of Tennessee*. Published at the order of the Court in the Clover Bottom suit in 1998, p. 84.

²⁹ Telephone interview with Bill Murray of Rhode Island, July 17, 1997, and Joyce Slayton of New Hampshire, July 18, 1997.

³⁰ Conversation with William Edington, Tennessee Department of Mental Health and Mental Retardation, July 10, 1998.

³¹ Proposed Settlement Agreement, Section V, Part A, Number 2.

³² *Ibid*, Section V, Part A, Number 6.

Division of Mental Retardation Services officials, however, reject this concern over identifying specialists in the community³³. They point to Section V, Part A, Number 5 of the proposed Settlement Agreement, which requires the state to ensure that “placements in the community are adequate to meet the needs of the individuals as presented in his or her ISTP [individual support and transition plan].” According to Section V, Part A, Number 1 the ISTP must contain a “description of the actions, supports and services required and the persons and providers responsible for achieving the desired outcomes” in the community before placement. However, the *Community Plan for West Tennessee*, which arose out of the earlier lawsuit concerning Arlington Developmental Center acknowledges that in some cases specialists were not established in the community for citizens upon departure from the Arlington Developmental Center.³⁴

Administrative Alternative: The Division of Mental Retardation Services should explore providing resource centers at the closed developmental centers where citizens could obtain specialized services. The Division should consider maintaining a framework of specialists even after closing Winston and other centers.

Comment by the Deputy Commissioner, Division of Mental Retardation Services:

All medical specialists providing services at [Clover Bottom Developmental Center] and [Greene Valley Developmental Center] are based in the community and either work on contract with the Developmental Centers or see people who are transported from the Developmental Centers to their offices and clinics in the community. Therefore, these specialty services are already in the community.

The Funding Issue

Some of the strongest objections to the Settlement Agreement have arisen over the issue of funding community placements. The parent-guardian association’s court expert interprets part III, Section F, (page 8) of the Settlement Agreement as giving the state an escape route to avoid the responsibility of funding some of the services in the agreement in their entirety.³⁵

Page eight of the agreement contains the following passage:

The State Defendants agree to make all reasonable efforts to pursue all sources of available federal and state funding to support the execution of their responsibilities under this Agreement. In selecting among alternatives that meet 1) the requirements of this Agreement, 2) the requirements of federal statutes, and 3) the professional judgment standard for constitutionally appropriate levels of care, it is agreed that it is appropriate for the State Defendants to consider the availability of resources, the cost-effectiveness of various programmatic and service options, e.g. the State’s Home and Community-Based Waiver under Medicaid, and the overall burden on the State’s budget.

³³ Telephone conversation with Nora Cannon, Senior Counsel, Tennessee Department of Mental Health and Mental Retardation, July 15, 1997.

³⁴ *Community Plan for West Tennessee*, Chapter IV, Section B, Page 4.

³⁵ Telephone interview with Parent-Guardian Associations’ expert Dr. Al Baumeister, Psychology Professor at Vanderbilt University, July 10, 1997.

The parent-guardian association's expert believes that this language leaves the state an alternative to funding home and community based services if federal funds disappear or other funding problems occur. Placing the contingency for funding on "the availability of resources," its "cost-effectiveness," or the size of "the overall burden on the State's budget" is bothersome to both the intervenors and the Court.³⁶ In his conditional approval of the Settlement Agreement, Judge Echols wrote that "an agreement to provide services only if the funds are available may result in inadequate services to class members."³⁷

Attorneys for the state disagree with the objections to the portion of the Settlement Agreement relative to funding. State attorneys believe that the state is bound by law to perform the duties enumerated in the Settlement Agreement upon approval.³⁸ Thus, there is not an option for the state to avoid providing the services. As required in the funding section, the state must meet the requirements of the Agreement, comply with federal statutes, and satisfy the professional judgment standard for constitutionally appropriate levels of care. The state contends that although it must meet all of the requirements in the Settlement Agreement, it does not have to go "above and beyond" the requirements. In the words of the Senior Counsel in the Tennessee Attorney General's office, the state does not have to, at all times, offer "the Cadillac version of services," as long as the state meets the terms of the Agreement and upholds the U.S. Constitution and federal statutes.³⁹

State expenditures for mental retardation community services have increased while expenditures for mental retardation institutional services have decreased. The estimated expenditures for mental retardation community services in Fiscal Year 1999 of approximately \$183 million reflect a 15.9 percent increase from the budget of \$153,903,800 in Fiscal Year 1998,⁴⁰ and an increase of over 24 percent from the budget of \$137,924,300 in fiscal year 1997.

The proposed budget for Fiscal Year 1999 included approximately \$154,788,800 in mental retardation developmental center expenditures. This reflects a decline of 7.9 percent from the 1998 budget of approximately \$168 million for such expenditures, and decline of over ten percent from approximately \$173,396,400 in actual expenditures for the 1997 fiscal year. Federal funds cover approximately two-thirds of these expenditures. With the closure of the Nat T. Winston Developmental Center and the continued emphasis on community placements, the state can expect the continued decline of expenditures for state institutions.

The Logistics of Managing Community Services

The intervenors have indicated their desire for the number of community placement offices to increase.⁴¹ Tennessee currently operates three primary Regional Offices of

³⁶ Interview with Parent Guardian Associations' expert Dr. Al Baumeister, July 10, 1997; July 3 memorandum of the Court, 9.

³⁷ July 3 memorandum, 9.

³⁸ Telephone interview with Dianne Dycus, Senior Counsel, Tennessee Attorney General's Office, October 6, 1997.

³⁹ Ibid.

⁴⁰ Budget figures in this report come from *The Budget 1997-98*, *The Budget 1998-99*, and *The Budget 1996-97*. Budget figures were adjusted to correspond with project expansions for FY1997-98.

⁴¹ Telephone interview with Parent-Guardian Associations' expert Dr. Al Baumeister, Psychology Professor at Vanderbilt University, July 17, 1997.

Community Services in Memphis, Nashville, and Knoxville⁴². Two satellite offices for Knoxville's region are located in Chattanooga and Greeneville and a satellite for the Memphis office is located in Jackson. Thus, in total six offices in the state of Tennessee oversee the delivery of home and community-based services.

In contrast, the state of New Hampshire, which has not operated a large residential facility for the mentally retarded since 1991, is divided into 12 regions, with an area agency that oversees each region's home and community-based services.⁴³ New Hampshire has twice as many regional offices of community services, although Tennessee is over four times larger in both land area and population. While state officials were hesitant to give a ratio of either the number of MR/DD citizens or square miles that should correspond to each community office for optimum quality of service, New Hampshire has operated with no large state residential facilities for longer than any other state.

On the other hand, Florida, with twice as many persons living in the community as Tennessee⁴⁴ and almost three times the total population of Tennessee, has 15 regional offices of community placement. Moreover, according to Florida officials, there is concern that 15 offices is too many. The General Assembly in that state is considering scaling back the number of community offices to eight.⁴⁵ Florida officials indicate that although increasing the number of regional offices can increase accountability and local control over the community placement process, infrastructure investments must accompany each added regional office to effectively increase accountability and control.

Administrative Alternative: The Division of Mental Retardation Services should consider increasing the number of community placement offices. Small states, such as New Hampshire, currently maintain more community placement agencies than Tennessee. In making this decision, the Division must determine whether investing state dollars into additional community placement offices would actually increase accountability and local control over the community placement process, or simply result in increased bureaucracy.

Comment by the Deputy Commissioner, Division of Mental Retardation Services:

I believe it is premature to consider increasing the number of community offices. The State is not a community provider of services. Rather, the State provides funding, oversight, monitoring, quality assurance, training, technical assistance, etc. It is more critical to increase the specialty staff and financial resources within the existing Regional Offices, before further dispersing the management expertise that we are developing in these offices. Also, further movement of staff and offices may prove to be disruptive

⁴² Interview with Janice Spillman, Director of Planning and Development, Tennessee Department of Mental Health and Mental Retardation, July 26, 1997.

⁴³ Interview with Joyce Slayton Associate Director of Developmental Services for New Hampshire, Jul. 18, 1997.

⁴⁴ Lynda Anderson, *Residential Service Provisions in Southeastern States: Patterns of Utilization and Expenditures* (Minneapolis: University of Minnesota, Research & Training Center on Community Living, 1997) Table 5.

⁴⁵ Telephone interview with Mr. Terry Foshee, Manager in Florida Department of Developmental Services, July 21, 1997.

during this most critical period of our development. I recommend that we re-visit this recommendation in 12-18 months after we have had more experience with the current model. As Independent Support Coordination matures, much of the local control and placement activities will improve.

Current Status of Tennessee and the Southern States in Residential Services for the Developmentally Disabled⁴⁶

An examination of the data reveals that the downsizing of Tennessee's developmental centers is proceeding at a faster rate than most southern states. Although the Settlement Agreement never specifically calls for the closing of the states' developmental centers, it does state that "all citizens must be provided services in the least separate, most integrated setting appropriate to meet his or her individual needs." Many concerned parties perceive such language, in addition to the closure of the Nat T. Winston Center, to signify the beginning of the end for Tennessee's developmental centers.

Large institutions (Table 1). In June 1997, the 50 states reported a total of 246 large (over 16 residents) residential, state-operated institutions for persons with mental retardation and developmental disabilities (MR/DD).⁴⁷ The term "large institutions" refers to facilities with over sixteen residents. All states except New Hampshire, Rhode Island, and Vermont operated at least one large MR/DD facility in June 1997. As Table 1 illustrates, all southeastern states currently operate at least one large MR/DD facility, with Tennessee operating three.

Closure of large, state institutions (Table 1). Between the years 1960 and 1971 only two large, state-operated residential facilities were closed in the United States.⁴⁸ The number of large, state-operated residential facilities that were closed after 1971 rose steadily, climaxing in the years between 1992 and 1996, when 60 such institutions were closed in the United States.⁴⁹ Since then, the number of facilities that were closed has declined, but many states are still planning significant reductions.

The Division of Mental Retardation Services closed the Nat T. Winston Developmental Center in Tennessee in the spring of 1998. West Virginia is the only other southern state planning to close a large state residential facility before the year 2000.

Elsewhere in the United States, Alaska and Hawaii each plan to close their only state operated large residential facility by the year 2000. If these planned closures are completed then Alaska, Hawaii, and West Virginia will join New Hampshire, Rhode Island, and Vermont in the category of states with no large MR/DD facilities. Additionally, Michigan

⁴⁶ Information for these tables is from *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1997, Report #51* (Minneapolis: Research and Training Center on Community Living, College of Education, University of Minnesota 1998).

⁴⁷ Robert Prouty and K. Charlie Lakin, eds, *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1997, Report #51* (Minneapolis: Research and Training Center on Community Living, College of Education, University of Minnesota 1998) 4.

⁴⁸ Ibid, 19.

⁴⁹ Ibid.

plans to operate only two large state institutions by 2000, and Minnesota plans to operate only one at that time.⁵⁰

Table 1: Number of Large State Institutions (Greater than 16 residents), Closures, and Planned Closures			
Southeastern State	Facilities Over 16 Residents	Total Closed 1960-1997	Planned Closures 1997-2000
Alabama	4	1	0
Arkansas	6	0	0
Florida	8	2	0
Georgia	6	2	0
Kentucky	3	2	0
Louisiana	9	0	0
Mississippi	5	0	0
Missouri	6	10	0
North Carolina	5	1	0
South Carolina	5	0	0
Tennessee	3	1	0
Virginia	5	3	0
West Virginia	1	3	1

⁵⁰ Ibid.

Population per 100,000 in large state institutions (Table 2). Over the past three years the number of persons with MR/DD living in large state-operated residential settings per 100,000 of each state's population has steadily declined. This statistic is referred to as the "placement rate." As Table 2 indicates, both Tennessee's placement average of 22.8 and the southern states' average of 27.7 are higher than the national average of 20.0 as of June 30, 1997. The national placement rate for large state institutions decreased from 21.9 in June 1996 to 20.0 in June 1997. Tennessee's placement rate for large state institutions decreased from 26.2 in 1996 to 22.8 in 1997.

Table 2: Population per 100,000	
Southeastern States	Population per 100,000 in Large state Institutions
West Virginia	3.3
Florida	10.5
Kentucky	16.3
Alabama	16.4
Tennessee	22.8
Missouri	25.1
Georgia	25.4
North Carolina	28.8
Virginia	28.8
South Carolina	36.1
Louisiana	43.9
Arkansas	49.6
Mississippi	53.7
S.E. Average	27.7
U.S. Average	20.0

Arkansas. Only Mississippi has a higher placement rate for large state institutions than Arkansas. According to officials in Arkansas, there is no movement to downsize state institutions.⁵¹ There is a home and community-based waiver program in operation there, but it is entirely optional. The primary difference between Tennessee and Arkansas is the lack of

⁵¹ Telephone interview with Mike McCreight, Director of the Division of Disabilities Services, State of Arkansas, June 25 1997.

pending litigation against the state of Arkansas. According to Tennessee officials, states that are aggressively downsizing are often states under litigation.

Table 3 shows the change in average daily population in large state-operated institutions in the southeast between 1990 and 1997. Although the average daily population of large state institutions decreased nationally between 1990 and 1997 by an average of 33.4 percent, the southern states' average population declined on average by only 24.9 percent. Tennessee's average daily population declined by an average of 32.8 percent between 1990 and 1997 for the fourth largest decline among the 13 southern states examined.

Table 3: Change in Average Daily Population in Large State MR/DD Facilities		
Southeastern State	% Change in Population 1990-1997	Average Daily Population 1997
West Virginia	-77.6%	68
Alabama	-43.1%	742
South Carolina	-34.9%	1,488
Tennessee	-32.8%	1,298
Missouri	-27.5%	1,349
Louisiana	-25.1%	1,965
Virginia	-24.9%	1,989
Florida	-22.6%	1,541
North Carolina	-18.7%	2,158
Kentucky	-9.3%	643
Mississippi	-4.9%	1,424
Georgia	-1.4%	2,039
Arkansas	-0.3%	1,256
S.E. Average	-24.9%	1,382
U.S. Average	-33.4%	1,123

Conclusion

The closure of the Nat T. Winston Center and provisions of the Settlement Agreement have created an expectation of further downsizing and/or closings of Tennessee's state institutions. The Tennessee Division of Mental Retardation Services should consider maintaining resource centers at the closed developmental centers to maintain a framework of specialists who specifically address the needs of the developmentally disabled.

The Division of Mental Retardation Services should be aware that officials from other states that have closed all large state institutions indicate that most, but not all, of the affected individuals were placed in private community settings. Those not placed in private community settings in New Hampshire and Rhode Island were placed in either mental health institutes or smaller state-operated residential facilities for the mentally retarded. The Tennessee Division of Mental Retardation has no plans to pursue either of these options. Nevertheless, the Division should consider the possibility of some individuals not being recommended to private community placements.

The Division of Mental Retardation should also consider increasing the number of community placement offices that it currently operates. Other states have indicated that they have more offices of community placement per population than Tennessee. More offices of community placement do not necessarily translate to an automatic improvement in services, however, according to other states that operate a greater number of offices.

Appendix 1: Persons Interviewed

Lynda Anderson
Research and Training Center on Community
Living
Institute on Community Integration/UAP
College of Education, University of Minnesota

Alfred A. Baumeister
Professor of Psychology
Peabody College, Vanderbilt University

Nora Cannon
Senior Counsel
Tennessee Department of Mental Health and
Mental Retardation

Ben Dishman
Acting Commissioner
Tennessee Department of Mental Health and
Mental Retardation

Dianne Dycus
Senior Counsel
Office of the Attorney General
State of Tennessee

U.S. District Judge Robert L. Echols
Middle District, Tennessee

William Edington
Director of Program Development
Tennessee Department of Mental Health and
Mental Retardation

Terry Foshee
Manager, Department of Children and Families
Division of Developmental Services
State of Florida

Mary Beth Franklin
Assistant Attorney General
Office of the Attorney General
State of Tennessee

Michael McCreight
Director, Division of Developmental Disabilities
Services
Department of Human Services
State of Arkansas

Bill Murray
Administrator of Financial Services
Division of Developmental Disabilities
State of Rhode Island

Dee Prescott
Administrator for Program Support
Division of Developmental Services
Department of Health and Human Services
State of New Hampshire

Dr. Robert Prouty
Research Fellow and Coordinator
Residential Information Systems Project
University of Minnesota

Al Quattromani
Associate Director
Division of Developmental Disabilities
Department of Mental Health, Retardation, and
Hospitals
State of Rhode Island

Walter Rogers
Director, Community Placements
East Tennessee Regional Office
Tennessee Department of Mental Health and
Mental Retardation

Joyce Slayton
Associate Director of Developmental Services
State of New Hampshire

Janice Spillman
Director, Office of Planning and Development
Tennessee Department of Mental Health and
Mental Retardation

Thomas Sullivan
Deputy Commissioner
Division of Mental Retardation Services
Department of Finance and Administration